LETTERS TO THE EDITOR

Hepatitis-B virus infection in sexually transmitted disease clinic attenders in an African city, (Jos, Nigeria)

Hepatitis-B virus (HBV) infection has become one of the most important infectious diseases the world over and especially in developing countries.[1]

Infection with HBV is predominantly parenteral. However, high prevalence of serologic markers of HBV among female prostitutes, STD clinic patients and homosexual men have been documented in many studies,[2] from developed countries. This study was therefore designed to determine the prevalence of HBsAg in patients attending the STD clinic in Jos University Teaching Hospital, Jos.

One hundred adults (65 males and 35 females) who were attending the STD clinic of the Jos University Teaching Hospital, were screened for HBsAg. One hundred sex and aged matched controls were also screened.

About 5 ml of venous blood was collected from each of the subjects between January and March, 1991. HBsAg was determined using the commercially available latex test kit (Biotex Laboratories).

The chi square test was used for statistical analysis.

Of the 100 STD patients sera assayed, HBsAg was detected in eight (7/65 males and 1/35 females). Of the 100 controls 11 were HBsAg positive, (8/65 males and 3/35 females). There was no significant difference in the carrier rates of the groups and their sexes ($p > 0.05$) even though there was a three fold increase in the males compared with the females in the STD group.

The high prevalence of HBsAg in both groups studied, STD and control patients (8% and 11% respectively) confirms the endemicity of HBV infection in Nigeria. There was no significant difference ($p > 0.05$) in the carrier rates of the two groups. This finding does not only suggest the endemicity of HBV infection in Nigeria but also the fact that sexual transmission may not play a significant role as a route of infection.

The figure (8·0%) obtained for the STD patients in this study compares favourably with that obtained in the study (9·2%) by Gan *et al*[3] among STD patients in Malaysia but was slightly higher than the figure (5·43%) obtained by Osoba *et al*[4] at Ibadan, Nigeria.

This low prevalence by Osoba may be due to the lower sensitivity of the Agargel immunodiffusion method, a first generation serologic assay method as compared with the latex agglutination second generation method used in this study.

This study has re-emphasised the endemicity of HBV infection in the developing countries and the urgent need for intervention to eradicate this disease with its attendant morbidity and mortality.

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C S S BELLO
S O OPAJOBI
Deparment of Medical Microbiology
S N OKOLO
Paediatrics
R S OLAREWAJU
Obstetrics & Gynaecology
L O IDOKO
Community Medicine, Faculty of Medical Sciences, University of Jos, Jos, Nigeria

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Malignant syphilis in a teenage girl

Syphilis, the great imitator was well recognised even in the 15th century as a sexually transmitted disease. Malignant syphilis has become of historical interest and is often associated with debilitation and poor socioeconomic conditions. Papulonodular syphilides are usually midway between the secondary and tertiary stages. Sometimes, they may be found in delayed relapse.[1] This type may be confused with variola, varicella and furunculosis. As a result of the adjustment of the host-parasite relationship and under the impact of modern therapeutic agents, syphilis has now become mild and hence violent malignant syphilis raises problems in diagnosis.

An unmarried teenage girl, attended the STD Department, Government Rajaji Hospital, Madurai with skin rashes over all the body and two ulcers, one on each leg, of 20 days duration, referred from the Dermatology Department for the exclusion of a diagnosis of syphilis. She had had treatment in the infectious diseases hospital for the previous 15 days. She had had sexual intercourse with an unknown male (only once) 5 months previously. No history of trauma in the legs, transfusion or intravenous injections were recorded.

On general examination, she was febrile and had papulonodular skin eruptions all over the body and two circular ulcers, one in each leg,

with mild crusting. There was no generalised lymphadenopathy. CVS, CNS, abdomen, ocular and genital systems were normal.

Blood VDRL titre was $\frac{1}{64}$ and blood TPHA was positive. Tests for HIV, slit smear test for *Mycobacterium leprae* were negative. Radiographic and CSF examinations were normal. Histopathological examination confirmed the diagnosis. *Treponeuma pallidium* was demonstrated from the lesions by darkfield microscopy. Her parents were normal. Her contact could not be traced.

She responded to antisyphilitic treatment well within 2 weeks. On follow up, she was clinically and serologically normal.

Malignant syphilis was observed during the great epidemic at the dawn of 16th century. Reports by Sehgal & Rege,[1] Yarovinsky & Kholin,[1] Buck,[1] and Lejman & Starzycki,[1] show that it is an uncommon presentation of secondary syphilis today.

Abundant, symmetrical, large papulonodular syphilides all over the body and 2 ulcerative legions with mild crusting present one in each leg in the early secondary phase without any history or relapse noticed in a 19 year old female differ from the description in the literature of few lesions, usually on the face and scalp in the late secondary or relapse or in early tertiary states.[2 3]

Weakening of a patient's immunobiological resistance due to various detrimental influences are believed to play a role in the pathogenesis of malignant syphilis.[4] The absence of any systemic diseases in our case suggested the role of secondary reversible defective cell mediated immunity in secondary syphilis, though this could not be confirmed for lack of facility.

Historical, serological, histopathological evidences and prompt therapeutic response confirmed the diagnosis of this early phase of secondary syphilis.

JEYAKUMAR WILLIAMS
4/112, Immanuel Cottage, Tasildharnagar, Madurai, Tamilnadu, India. 625020.

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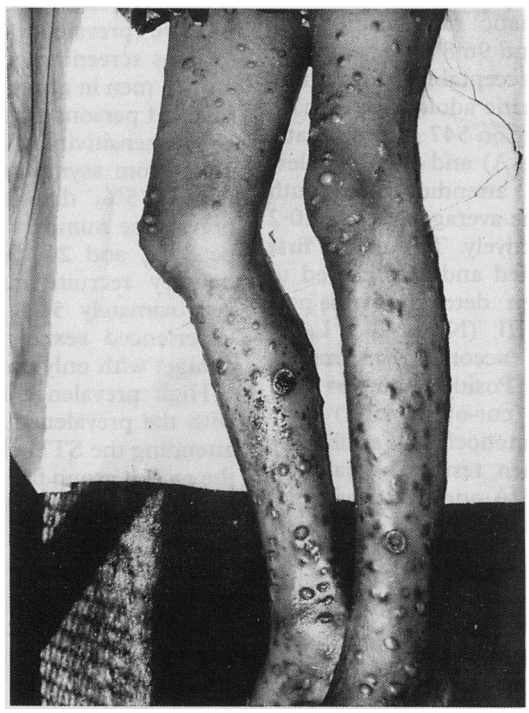

Fig Numerous papulomodular and two ulcerative syphilides on the lower limbs.

An increase in pharyngeal gonorrhoea: cause for concern regarding HIV infection

With the exception of 1985, there was a decline in laboratory reports of male rectal gonorrhoea in England and Wales between 1981 and 1989. In 1990 however, there was a four-fold increase compared with 1989; a large proportion, but not all this increase centred in one London clinic. KC60 data for new cases of gonorrhoea (excluding pelvic inflammatory disease) at genitourinary medicine clinics in England and Wales showed an increase in attendance rates of 7·5% for males and 6·2% for females compared with 1989. This was the first increase in cases of gonorrhoea for sixteen years and continued into 1990 in males.[1] The proportion of homosexually acquired infection doubled between the first quarters of 1989 and 1990, and there have been several reports of recent increases in rectal gonorrhoea in homosexual men.[2–4]

In Newcastle we have seen a different pattern of infection emerging (see table). Total cases of gonorrhoea have fallen steadily over the last few years. There was a rise in 1991 in homosexually acquired gonorrhoea but the proportion with rectal infection has fallen from 43% in 1990 to 20% last year. Pharyngeal gonorrhoea however has increased markedly in homosexual men, occurring in 55% in 1991, as opposed to 29% in 1990. The throat was the solitary site of infection in 64% in 1991.

These data may reflect a change in sexual behaviour in homosexual men attending our clinic. The increase in cases of gonorrhoea seen in this group last year can be accounted for by the increase in pharyngeal infection. Information leaflets about safer sex stress the risks of HIV transmission through unprotected anal intercourse, while the risk of HIV infection by oral sex is stated to be very low. Dr Murray and colleagues reported a case of coincident acqui-

Table Gonorrhoea in Newcastle 1987–1991

	Total gonorrhoea		*Gonorrhoea in homo/bisexual men*		
	All sites	*Pharynx*	*All sites*	*Pharynx*	*Rectum*
1987	387	21	18	5	7
1988	268	19	16	2	6
1989	205	17	12	5	4
1990	178	12	14	4	6
1991	155	20	20	11	4